MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
MC+ INSURANCE PREMIUM PAYMENTS
AUTOMATIC WITHDRAWAL AUTHORIZATION OR CHANGE
(START, CHANGE, OR CANCEL)

Please allow 30 days for automatic withdrawal to start/change/cancel. When the automatic withdrawal is effective you will not receive a monthly invoice. Continue to pay the monthly invoices you receive until then. If you need help filling out the Automatic Withdrawal form, or to verify the effective date, call toll free at 1-877-888-2811.

- ❑ Start I want the Missouri Department of Social Services to withdraw the MC+ Insurance Premium from my account.
- ❑ Change I want the Missouri Department of Social Services to change automatic withdrawal to the bank account named below
- ❑ Cancel I want to cancel the automatic withdrawal of the MC+ Insurance Premium.

Part A - Account Information

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION

- Check the box that tells if you are using a checking account or a savings account.

- ❑ Checking (Attach a blank check with VOID written across it.)
- ❑ Savings (Attach a savings deposit slip showing your account number with VOID written across it.)

Bank Routing Number - Write your financial institution's routing number printed at the bottom left portion of your checks or deposit tickets (the first 9 numbers).
Bank Account Number – Write the account number printed on the bottom of your checks following the routing number. It may be the first numbers after the routing number followed by your check number (example 1), or the numbers that follow your check number (example 2). (See examples on page 2) The check number is NOT part of the account number.

Bank Routing Number _ _ _ _ _ _ _ _ _ Bank Account Number _____

Name of Financial Institution_____

Address of Financial Institution (Street) _____

(City) _____ (State) _____ (Zip Code) _____

Financial Institution Telephone Number (_ _ _) _ _ _ - _ _ _ _

Mail both pages of the Automatic Withdrawal Authorization form to: Division of Medical Services, Financial Services Unit, P.O. Box 6500, Jefferson City, MO 65102-6500.

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Part B – Agreement

I hereby authorize the withdrawal of health insurance premiums on or around the 15th of each month from my checking or savings account with the financial institution indicated above. The premium amount will vary month to month based on family size and income and can be from $12.00 to $257.00. I understand that the amount will change annually as the premium rate changes, and authorize continued automatic withdrawals. Withdrawals will be made monthly unless I choose to terminate this agreement. I understand that the Division of Medical Services will make a reasonable effort to complete this transaction in a timely manner. I recognize that it is my responsibility to have the funds available in the account indicated above for the withdrawal of my monthly premium payment.

SIGNATURE OF PARENT OR GUARDIAN

_____DATE_____

Telephone Number (_ _ _) _ _ _ -_ _ _ _

Part C – Customer Information

Policy Number/Case Head ID _ _ _ _ _ _ _ _ _ Name _____

Telephone Number (_ _ _) _ _ _ - _ _ _ _

Example 1

FINANCIAL INSTITUTION CHECK NO. 1234
HOMETOWN, USA

PAY TO THE ORDER OF _____

123456789 8765432109812 1234

ROUTING # **ACCOUNT #** **CHECK #**

Example 2

FINANCIAL INSTITUTION CHECK NO. 1234
HOMETOWN, USA

PAY TO THE ORDER OF _____

123456789 1234 8765432109812

ROUTING # **CHECK #** **ACCOUNT #**

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